SKYLINE DENTAL, LLC

PATIENT INFORMATION

Name _____ Prefer to go by:_____ Today's Date _____

Address _____ City, State & Zip _____

Home Phone _____ Work Phone _____ Cell or Message Phone _____

Date of Birth _____ Email _____

How do you prefer our office to contact you for appointment confirmations? Email [ ] , Text [ ] , Phone [ ] , All [ ]

Marital Status (please check box): Single [ ] , Married [ ] , Widowed [ ] , Divorced [ ] , Other [ ]

RESPONSIBLE PARTY INFORMATION

Name of Responsible Party (guardian) _____ Social Security # _____
(For billing purposes … not necessary if paying in full at time of service)

Address (if different than patient) _____
City, State & Zip

Occupation _____ Employer _____ Employer / Work Phone _____

How would you like to pay for your portion of the provided services? Cash [ ] , Check [ ] , Credit Card [ ] , Other [ ]

RESPONSIBLE PARTY'S SPOUSE

Name of Responsible Party (guardian) _____ Social Security # _____
(For billing purposes … not necessary if paying in full at time of service)

Address (if different than patient) _____
City, State & Zip

Occupation _____ Employer _____ Employer / Work Phone _____

DENTAL INSURANCE

Insurance Company _____ Insured Name _____

Insured DOB _____ Subscriber Number _____

Group # _____ Employer _____

Insurance Co. Address _____
City, State & Zip

Insurance Co. Phone # _____

SECONDARY DENTAL INSURANCE

Insurance Company _____ Insured Name _____

Insured DOB _____ Subscriber Number _____

Group # _____ Employer _____

Insurance Co. Address _____
City, State & Zip

Insurance Co. Phone # _____

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MEDICAL HISTORY

Please keep us updated on any future changes to your medications, allergies or medical history.

General Health: Good [ ] , Fair [ ] , Poor [ ]

Physician's Name _____ Last Complete Physical _____

Are you currently on ANY medications (prescribed, over the counter, vitamins or herbals)**? Yes [ ] No [ ]**
If 'Yes', please list medications and purpose:

_____ _____

_____ _____

_____ _____

Are you allergic to any medications? Yes [ ] No [ ] _____

If 'Yes', please circle or list: _____

Penicillin Codeine Latex Local Anesthetics _____

Please mark the boxes which apply to you and your Medical History:

[ ] Need antibiotic coverage prior to dental work
[ ] Artificial joint replacement
[ ] Undergone radiation treatment for _____
[ ] Undergone IV Chemotheraphy for _____
[ ] Use or have used tobacco products in the past
[ ] Subject to prolonged bleeding
[ ] Excessive thirst and or urination
[ ] Subject to fainting
[ ] Recently hospitalized or past surgeries _____
[ ] (WOMEN) Currently pregnant? How far? _____
[ ] (WOMEN) Currently nursing?

Please mark the boxes below, if you are *currently, or have ever been diagnosed or treated* for:

[ ] Heart Disease
[ ] Heart Murmur
[ ] Congenital Heart Defects
[ ] Rheumatic Fever
[ ] Abnormal Blood Pressure
[ ] Stroke
[ ] Cancer (Type _____)
[ ] Difficulty Breathing / Short of Breath
[ ] Tuberculosis or Lung Disease
[ ] Diabetes (Type _____)
[ ] Ulcers / Colitis
[ ] Acid Reflux
[ ] Epilepsy or Seizures
[ ] Anemia
[ ] Hemophilia
[ ] Jaundice or Hepatitis (Type _____)
[ ] Kidney Disease or Dialysis
[ ] Asthma or Hay Fever
[ ] Sinus Problems or Chronic Cough
[ ] Sleep Apnea
[ ] Osteoporosis or other type of Bone Disease
[ ] Thyroid Disease
[ ] Hives or Skin Rash
[ ] Glaucoma
[ ] Long-Term Steroid Treatment
[ ] Autoimmune Disorders
[ ] AIDS / HIV
[ ] Drug or Substance Addiction
[ ] Eating Disorders (Current or Past)
[ ] Neck or Back Problems

YES	NO	Other
		Do you have any other medical or health condition which is not listed? _____
		Is there any condition or issue that you prefer to talk to the Doctor in private about?

Notes & Updates: _____ **(For Office Use Only)**

_____ Updated: _____ Pt. _____ Staff _____

Payment Agreement: *In the event that this account is turned over to a collection agency or attorney for collection of any of the fees due herein; I hereby agree to pay all collection agency fees and all attorney fees, whether or not a lawsuit is instituted. I also acknowledge that I would be responsible for all court costs incurred in making collection of sums due and unpaid for the work herein set forth. Delinquent accounts which have to be turned over to a Credit Reporting Collection Agency will have their balances increased 50% to cover the expenses associated with the Collection Agency. In addition to these collection agency expenses, delinquent accounts are also liable for Attorney fees and court costs associated with the collection of the debt.*

Patient or Responsible Party Signature _____ Date _____